Good

Dudley and Walsall Mental Health Partnership NHS Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYK33	Trust Headquarters	Dudley Older Adults Community Mental Health Team	DY2 0SZ
RYK33	Trust Headquarters	Walsall Older Adults Community Mental Health Team	WS3 1LZ

This report describes our judgement of the quality of care provided within this core service by Dudley and Walsall Mental Health Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Dudley and Walsall Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Dudley and Walsall Mental Health Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated community-based mental health services for older people as **good** overall because:

- In both teams, the duty worker system enabled a same day response to urgent referrals and any crisis calls from existing service users, their carers or other professionals. Making use of the detailed crisis plans prepared by case managers, the duty worker was able to prepare an individualised response to a particular service user's immediate needs.
- In our previous inspection in February 2016, we had found all of the service users' records that we checked had completed risk assessments in place and there was clear evidence of review and update. The trust had conducted an internal case note audit in May 2016 that had identified incomplete risk assessments in a majority of the 40 records examined. Managers had put in place a plan to improve this shortfall. We found, on this inspection, that initial risk assessments were present for all service users. Staff had completed more detailed risk assessments in 75% of the care notes we reviewed. Where appropriate crisis management plans had also been.
- Managers at Walsall had acted promptly to ensure the safety of service users during a period of high levels of sickness. They used bank staff and experienced staff from other areas of the trust to monitor caseloads and maintain the duty worker system.
- We found both teams had regular meetings in which staff could discuss incidents and lessons learnt from their own team, the older adult service and other areas of the trust.
- Service users and carers told us that they felt safe in the care of the teams and confident that staff would respond promptly to any urgent concerns they might have.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We re-rated safe as good because**:**

- Both teams were able to respond to urgent need and provide same day home visits to those requiring early assessment following referral into the service.
- Managers operated an effective system of caseload management that took into account the individual needs of service users.
- Managers acted promptly to provide cover for sickness and other absences to secure the safety of the service and continuity of care
- We found that staff completed initial risk assessments for all service users at referral. These were developed into full risk assessments for the vast majority of service users that were regularly updated. When case workers had completed crisis plans we found them to be detailed with a clear explanation of potential risks and triggers linked to actions to be taken including the use of other agencies, carers and family members to support the service user in crisis.
- We found improvements in the management and transport of medication since the last CQC inspection. The trust's central pharmacy team provided oversight, auditing medicines management every other month.

However:

- Managers had not provided any training on physical health for staff to support the introduction of a new physical health risk assessment. Staff told us they had received no support on taking physical observations, or guidance on the action they should take in the event they detected any abnormality.
- Managers had not introduced training for staff in personal safety as recommended at our last inspection.
- Managers had not updated the lone working protocol to support the safety of staff working alone out of hours ahead of the planned expansion of working hours for the Walsall team. Staff expressed concern that they had not been able to familiarise themselves with this new protocol within a week of its planned introduction.

Summary of findings

Are services effective? At the last inspection in February 2016 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 
Are services caring? At the last inspection in February 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 
Are services responsive to people's needs? At the last inspection in February 2016 we rated responsive as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 
Are services well-led? At the last inspection in February 2016 we rated well-led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 

Summary of findings

Information about the service

The community based mental health services for older people at Dudley and Walsall Mental Health Partnership NHS Trust consisted of two community mental health teams, one in Dudley and the other in Walsall, a day hospital in Dudley, a community therapy team and a memory service both based in Walsall.

The Woodside Centre is the base of operations for the Dudley community-based mental health services for older people and has a caseload of around 350. It delivers treatment and therapy in the community and has a team comprised of community psychiatric nurses (CPNs), health care assistants (HCAs), an occupational therapist and social workers.

Birch Day Hospital was based at Bushey Fields Hospital in Dudley. We did not visit this service as part of the current inspection.

The Blakenall Village Centre is the site of all the Walsall community-based mental health services for older people. The community mental health team has a caseload of around 540. It delivers treatment and therapy in the community and has a team comprised of a combination of community psychiatric nurses (CPNs), health care assistants (HCAs), occupational therapist and social workers.

The therapy and liaison community service (TALCS) and Walsall memory service share this site. They were not part of the current inspection. Beeches Day Hospital, which was based at Bloxwich Hospital, had been closed and TALCS introduced in its place.

The last comprehensive inspection of the trust was in February 2016. At that time the service was rated as good overall and in each of the five domains (safe, effective, caring, effective and well led) reported on.

Our inspection team

Our inspection team was led by:

James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The sub-team which inspected this core services comprised two CQC inspectors

Why we carried out this inspection

We inspected the community based mental health services for older adults as a focussed inspection to explore concerns raised by staff about the safety of the service. The trust's last comprehensive inspection was in February 2016.

When we last inspected the trust in February 2016, we rated community based mental health services for older people as **good** overall.

We rated the core service as good for safe, effective, caring, responsive and well-led.

We found a number of issues of concern at the time and told the trust to address these. These included:

- The provider should develop personal safety training specific to the service.
- The provider should include personal safety and mental health act training sessions as part of its mandatory training calendar
- The provider should ensure that all safety equipment is maintained and operational
- The provider should develop policy and local protocols linked to agile working

As part of the broader re-inspection of other core services in November 2016, we heard staff express concerns about the safety of care at the two older adult community mental health teams. Their particular concern was the planned introduction of a new model of care in Walsall on 5 December 2016, as managers had not agreed the operational policy, staff rota or any arrangements for

Summary of findings

medical cover. Staff felt that the trust was committed to implementing change without regard for their concerns, which they had raised internally throughout a process of consultation.

The trust had proposed an expansion of working hours into weekday evenings and at weekends for the community services for older adults as an enhanced model of care. Managers explained that these changes would provide specialist older adult mental health workers to support clients in crisis. This would improve the existing system in which older adults, requiring emergency support outside of office hours, relied on the crisis team for working age adults for non-specialist support.

This inspection focused on the two older adult community mental health teams in Dudley and Walsall to assess their ability to deliver a safe service given the concerns raised.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection, we reviewed information that we held about community-based mental health services for older people and requested information from the trust. This information suggested that the ratings of good for effective, caring, responsive and well led, that we made following our February 2016 inspection, were still valid. Therefore, during this inspection, we focused on those issues about safety that staff at the trust had raised.

During the inspection visit, the inspection team:

- Visited both team bases
- Spoke with the service manager, the two team managers and two deputy team leaders, one for each of the teams
- Spoke with two consultant psychiatrists
- Spoke with six qualified nurses at the Dudley team
- Spoke with eight qualified nurses, a support worker and two social workers at the Walsall team
- Spoke with and observed the duty worker at each team
- Spoke with the trust's staff side lead
- Spoke with two service users and two carers
- Reviewed electronic care records for 12 service users

What people who use the provider's services say

We spoke with two carers and two service users who use the service. They all reported that the community mental health teams for older people were very responsive to their needs and responded promptly to any requests for help. One carer told us that in response to worries about his wife a community nurse visited their home within a few hours of his initial call. All had appropriate contact details for the community teams during working hours and for the crisis team at other times. They all felt safe in the care of the service and confident that staff would listen to any concerns they had.

Good practice

Areas for improvement

Action the provider MUST take to improve

Summary of findings

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The trust must ensure that staff complete and update risk assessments and risk management plans for all service users.
- The trust should ensure that the staff are aware of the operational protocol to support the introduction of the cardio metabolic risk assessment.
- The trust should provide education on physical health assessment to support the assessment and recognition of physical health problems.
- The trust should ensure that staff undertake personal safety training tailored to the potential risks of the service's service user group.

Dudley and Walsall Mental Health Partnership NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Dudley Older Adults Community Mental Health Team	The Woodside Centre, Highgate Road, Holly Hall, Dudley
Dudley Older Adults Community Mental Health Team	Blakenall Village Centre, Thames Road, Blakenall, Walsall,

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Neither of the community mental health teams saw service users on their premises. Staff visited service users in their own homes or at the local hospital out-patients clinics.

Safe staffing

Staffing Levels (Whole Time Equivalents):

- Dudley CMHT: Team Manager, Clinical Lead, 10.2 WTE Band 6 Community Psychiatric Nurses, 2.3 WTE Band 3 Community Support Workers, 4.6 WTE Social Workers, 1 WTE Assistant Care Co-ordinator and 1 WTE Occupational Therapist.
- Walsall CMHT: Team Manager, Clinical Lead, 7.4 WTE Band 6 Community Psychiatric Nurses, 3 WTE Band 5 Community Psychiatric Nurses (2 posts temporarily covering sickness at Band 6),1.6 WTE Band 3 Community Support Workers, 2 Advanced Social Work Practitioners, 5 WTE Social Workers and 1.6 WTE Occupational Therapists.

Vacancies:

- Dudley OA CMHT 0.8 WTE Band 6 Community Psychiatric Nurses, 1 WTE Social Worker,
- Walsall OA CMHT 3.6 WTE Band 6 Community Psychiatric Nurses, 2.2 WTE Band 3 Community Support Workers

Staff sickness rate (%) in 12 month period until 31 October 2016:

- Dudley CMHT 1.5% and Walsall CMHT 6.4%. For Walsall, there had been a peak rate of sickness in August 2016 at 13%

Staff turnover rate (%) in 12 month period until 31 October 2016:

- Dudley CMHT 3.2 % and Walsall 2.8%
- Managers had agreed upon the number of staff using formulae that matched estimated demand against the capacity of the services to support individual clinical caseloads and maintain a duty system to respond to urgent need. An external management review in 2015 had proposed that there was additional capacity available for the teams to make more contacts and meet demand with fewer staff. The proposed reductions in staff had not taken place and managers had used this analysis to inform plans to expand the services into weekday evening and weekend working. Managers, working alongside the local commissioners, had originally planned to introduce this enhanced model of care to Walsall in October 2016. However, when managers had produced rotas that included the new shifts there was a shortfall between staff available and numbers required. The original timescales had not allowed for the recruitment of the additional 3.6 WTE community psychiatric nurses required before the service was to start.
- Managers attempted to block book suitably experienced and qualified agency nurses to fill this gap and allow the service to commence at a revised start date of 5 December 2016. However, they had only secured one agency nurse to fulfil this role by the time of our inspection. Having reviewed the planned rotas ability to meet the new duty arrangements, managers recognised that they could not cover the outstanding gaps without a negative effect on the existing service. This was one factor in the decision made by members of the trust executive team on 1 December to delay the start of the new service until January 2017. Managers had plans to introduce the new model of care to the Dudley team but that proposal was still in consultation at the time of our inspection.
- Managers calculated individual caseloads by matching the capacity of a worker to make a number of service user contacts per month with the expected needs of the service users on their caseload. This related to a key performance indicator that caseworkers should make four visits a day. Together the team leader and case manager used a caseload management tool to determine the needs of an individual service user and the number of support visits they might require. Therefore, a caseworker might hold a smaller number of

more intensive cases than one of their peers. The aim of using the case management tool to review caseloads in detail on a monthly basis was to allow managers to ensure they fairly shared work between caseworkers.

- There were no waiting lists in operation and the maximum waiting time until the allocation of a key worker for non-urgent service users was one week until the allocation meeting was held. All service users received a call from the duty worker on receipt of their referral into the service to arrange an initial visit.
- We found robust arrangements in place to cover the duty rota in the case of sickness or other absence. Managers would review caseloads in the case of longer-term absence and ensure that service users were supported by other members of the team. During the summer of 2016, the Walsall team had experienced high levels of sickness over the period of three months. The team leader and service manager had acted promptly to maintain the safety of the service and brought staff nurses from the inservice user unit into the team to cover caseloads.
- Where team leaders had used agency or bank staff to cover periods of sickness, they interviewed them in advance for suitability of skills and experience and offered an initial period for induction to the team. When possible managers had block booked any bank and agency staff to ensure continuity of care.
- Team members interviewed all commented positively on the availability of specialist old age psychiatrists to offer advice or support as required within their normal working hours
- Medical cover was not yet finalised for the proposed expansion of working hours in the Walsall service. Staff were concerned that the trust wide medical duty rota would be used as opposed to always using old age psychiatrists. Managers had recognised the risk attached to this plan as a further reason to delay the implementation of the service.
- The average mandatory training rate for this core service was 90%. No element of mandatory training had a completion rate below 75%. Our last inspection report advised the trust that they should include personal safety and mental health act training sessions as part of its mandatory training calendar. We saw evidence that community staff received mental health act training but not as part of their mandatory training. Managers had not introduced and made mandatory service specific personal safety training. Training levels in conflict resolution, which would provide staff with skills to de-escalate potential conflicts, were 63% in Walsall and 75% complete in Dudley at the end of October 2016.

Assessing and managing risk to service users and staff

- We saw evidence that staff recorded an initial risk assessment at the first assessment interview with a service user. If referral information indicated any risks of potential harm to others, the duty worker would make a provisional risk assessment that two workers may be required for safety or could arrange an appointment at an outservice user centre. When the service assessed a service user as needing support from them, the caseworker was expected to complete a full risk assessment within 28 days. The trust used the Functional Assessment of Care Environments (FACE) risk assessment in the version adapted for older adults that formed part of the electronic service user record.
- The trust had provided the CQC with the results of an internal audit carried out in May 2016 (with a sample size of 20 case notes at each community mental health team). It had found an up to date and completed FACE risk assessment in place within 50% of the records at Dudley and 40% at Walsall.
- The annual audit in 2015 had found up to date risk assessments in 90% of cases at Walsall and 100% in Dudley.
- The 2016 audit found that in 50% of cases at Dudley and 60% in Walsall there was a risk management plan evident.
- In 2015, the number of risk management plans evident had been higher with 80% in Walsall and 85% in Dudley. From our discussion with the service manager, there had been local actions to improve these figures following these audit results.
- We reviewed 12 risk assessments; six at each team for service users with a current community allocated key worker.
- At Walsall, we found all six records reviewed had evidence of an initial risk assessment at first contact. However, only one service user had no current FACE risk assessment although they had been in the service for

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

more than 28 days. Of the other five, two risk assessments were incomplete and did not include a crisis plan. Reviews were overdue on three of these risk assessments.

- At Dudley, we found all six records reviewed had evidence of an initial risk assessment at first contact. All six service users had a current and complete FACE risk assessment. Only one of the six did not have a crisis plan completed. There was evidence of recent reviews of all six risk assessments and any changes were also reflected in the care programme approach (CPA) plans reviewed.
- Overall 75% of our sample had a full FACE risk assessment and 66% had a crisis plan in place. Only one service user (8% of the sample) had no FACE risk assessment. These results reflect a positive change in the rates of completion since the audit in May 2015. The lowest rates of completion remained in Walsall, which had experienced staffing problems during the summer of 2016. However, local managers had worked to prioritise service user safety by focusing on completing risk assessments and keeping case notes up to date in the absence of regular staff.
- Where we did find evidence of crisis plans, they were detailed with a clear explanation of risks, the associated warning signs and actions to be taken including the use of other agencies, carers and family members to support the service user in crisis.
- The duty system at each team allocated an experienced community case worker as a first point of contact for any calls seeking urgent help. They were supported by a second caseworker who was available to support the designated duty worker if they needed to go out and respond to a crisis with a known service user or urgent referral. The duty worker could also signpost the call to the emergency services if their assessment suggested the service user or others were at immediate risk.
- There were no waiting lists for assessment by the two teams. The service had a three-tier admission assessment process. This meant that the duty worker could assess service users in crisis within four hours, service users considered as urgent were assessed within 48 hours and non-urgent service users were assessed within 15 days. At the initial assessment, staff decided if a person needed to be admitted to the service at which point they assigned a care co-ordinator to them. That initial interview could also lead to the person being signposted to other services for support as appropriate.
- Staff received mandatory training in safeguarding and were aware of how to make a safeguarding alert. At both the Dudley Older Adults Community Mental Health Team and the Walsall Older Adults Community Mental Health Team, the clinical leads were nominated as safeguarding leads and were on site nine to five Monday to Friday to offer support if this was required. The training rates in the year between November 2015 to October 2016 for adult and children safeguarding were 83% and 98% respectively for Dudley and 95% and 98% for Walsall.
- There was a lone working policy in place. However, the trust had not updated this policy to reflect changes in working practices already introduced or planned. Although the need to do this had been highlighted in our previous report published in May 2016, the policy we found in place was last reviewed in January 2016. However, all staff interviewed had a very clear understanding of their obligations to make their whereabouts known, the emergency procedures if they were to find themselves in trouble and their responsibility to check on their colleagues' safety.
- The proposal to extend working hours at Walsall required the team member to work from a new base that they were unfamiliar with, alongside the crisis team for younger adults. There would be, at times, no other member of the older age service at work and the existing practice of having at least one colleague from your team always aware of your whereabouts would not be possible.
- Staff had already raised these concerns about personal safety as part of the internal consultation process and managers had not agreed a final operational policy to inform staff until only two working days before the new service was to start. An earlier plan to allow members of the team to spend time at the new out of hours base and familiarise themselves with the local team and protocols had not been possible due to time pressure.
- The service had reviewed the management and transport of medication since the last CQC inspection. Managers had provided new bags to ensure the secure

Good

Are services safe?

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transport of medicines and both teams had established protocols on signing out medicines and recording stock levels. There was also oversight from the centralised pharmacy team to review medicines management every other month and the team leaders received reports of their audits. This helped staff manage medicines safely.

Track record on safety

- Two serious incidents had been reported, one by each team, since November 2015. One related to an unexpected death in the community and was the subject of an ongoing coroner's inquiry. The other related to an attempted suicide at a service user's home.

Reporting incidents and learning from when things go wrong

- All staff interviewed were confident in describing the electronic incident reporting system used by the trust and when they might use it. They were aware of what constituted an incident and were able to state the correct course of action that would be required if they occurred.
- Staff we interviewed were all aware of their duty of candour to be open with service users and carers about any errors or following incidents.
- In the twelve months until the end of November 2016, Dudley older adult community mental health service had recorded 65 incidents and Walsall 70. In both teams', the majority of recorded incidents related to clinical care, assessment and the mental health act with staff reporting 42 incidents in this category at Dudley and 48 at Walsall.
- Both services had a monthly staff meeting. Managers ensured that any learning from investigation of incidents was always an agenda item. All staff were required to attend the monthly staff meetings.
- The trust also shared lessons learnt across the organisation in a regular bulletin available on the trust intranet.
- Following a serious incident the trust provided a service to support and debrief staff involved or affected by the event.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

At the last inspection in February 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

At the last inspection in February 2016 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

At the last inspection in February 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

At the last inspection in February 2016 we rated well-led as good.Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.